Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

City Crown Home Health Agency, Inc.,
PTAN: 45-7908,

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-89

Decision No. CR3130

Date: February 25, 2014

DECISION

I enter summary judgment in favor of the Centers for Medicare & Medicaid Services (CMS), sustaining its determination to revoke the Medicare enrollment and billing privileges of Petitioner, City Crown Home Health.

I. Background

Petitioner is a home health agency in Friendswood, Texas that participated in the Medicare program. A Medicare contractor acting on behalf of CMS determined to revoke Petitioner's Medicare enrollment and billing privileges effective July 23, 2013. Petitioner requested reconsideration and reconsideration was denied. Petitioner then requested a hearing and the case was assigned to me.

CMS moved for summary judgment. With its motion CMS filed 21 exhibits that it identified as CMS Ex. 1 – CMS Ex. 21. I receive these exhibits into the record. Petitioner filed six exhibits that it identified as Exhibit A – Exhibit F as an

attachment to its hearing request. It now requests that I receive them into the record and consider them as fact exhibits in opposition to CMS's motion for summary judgment. I deny Petitioner's request for the reasons that I explain below.

II. Issue, Findings of Fact and Conclusions of Law

A. Issue

The issue in this case is whether CMS is authorized to terminate Petitioner's Medicare enrollment and billing privileges for non-compliance with Medicare participation requirements.

B. Findings of Fact and Conclusions of Law

Providers and suppliers may participate in the Medicare program and receive reimbursement for their services to eligible beneficiaries only if they comply with all applicable laws and regulations governing their participation. CMS is authorized to revoke the Medicare enrollment and billing privileges of any participating provider or supplier that is not complying with enrollment requirements. 42 C.F.R. § 424.535(a)(1).

The application for participation in Medicare explicitly imposes on a home health care agency (or any provider or supplier) the obligation to comply with all Medicare participation requirements. An applicant signs a certification in which it expressly agrees that it is bound by these requirements. CMS Ex. 20. When Petitioner applied to participate in Medicare it not only subjected itself to applicable laws and regulations but it expressly agreed that it was doing so.

"Home health services" includes items or services furnished to an individual who is under the care of a physician, by a home health agency, "under a plan . . . established and periodically reviewed by a physician." Social Security Act (Act) § 1861(m). A physician must certify that home health services are necessary in order that they be reimbursable by Medicare. 42 C.F.R. § 424.22(a).

A written certification means more than a physician's signature on a form. "Certification" means that a physician has a treatment relationship with a patient, that he or she sees and evaluates that patient, and that he or she determines and attests in writing that the patient needs the services that are provided by a home health agency. Governing regulations envision that a physician will premise his or her certification on a face-to-face encounter with a beneficiary in which the physician evaluates the beneficiary's needs and determines that the beneficiary needs skilled nursing care or physical or speech therapy and that the beneficiary is

confined to the home except when receiving outpatient services. 42 C.F.R. § 424.22(a)(1)(i), (ii). The physician must establish a comprehensive plan of treatment for the beneficiary. 42 C.F.R. § 424.22(a)(1)(iii). The physician must sign the certification at the time that the plan of treatment is established or as soon thereafter as is practicable. 42 C.F.R. § 424.22(a)(2).

Failure by a home health care agency to obtain the proper certification by a physician for home health services is a violation of participation requirements. It is a basis for CMS to revoke that agency's Medicare enrollment and its billing privileges. 42 C.F.R. § 424.535(a)(1). A single instance of failure to provide proper certification is sufficient grounds for revocation.

The undisputed material facts of this case are that Petitioner claimed home health services reimbursement for several beneficiaries whose care had not been certified by a physician consistent with regulatory requirements. They establish that Petitioner claimed reimbursement for beneficiaries whose need for home health care ostensibly was certified by a physician, Dr. Bernadette Iguh, when in fact, Dr. Iguh had not certified these beneficiaries for home health services. CMS Ex. 6. These facts amply justify the determination to revoke Petitioner's Medicare participation and billing privileges.

Petitioner argues that there is a fact dispute as to whether the services in question were certified by Dr. Iguh. It contends that the exhibits it offers establish a fact dispute because they show that at least in some instances the beneficiaries whose services are at issue had a treatment relationship with Dr. Iguh.

However, Petitioner offered none of these exhibits during either the initial determination or reconsideration determination phase of this case and has not established any good cause for its failure to provide them then, when it had the opportunity to do so. For that reason I exclude them.

The hearing and decision in this case are governed by regulations at 42 C.F.R. Part 498. These regulations state explicitly that in a provider or supplier enrollment appeal such as this case an administrative law judge must examine any new documentary evidence that is offered by a provider or a supplier and determine whether good cause exists for receiving that evidence. 42 C.F.R. § 498.56(e)(1). The administrative law judge must exclude any new documentary evidence if there is no finding of good cause for the provider or supplier's failure to offer that evidence at the initial determination or reconsideration determination levels. 42 C.F.R. § 498.56(e)(2)(ii).

The regulations do not define "good cause" but that term universally has been determined to mean an event beyond a party's control that prevents the party from offering the evidence timely. Petitioner has offered nothing that would satisfy this criterion. It hasn't contended that anything prevented it from offering its exhibits during the initial determination or reconsideration process. By the time Petitioner requested reconsideration it knew that the contractor, acting on behalf of CMS, had determined to revoke its Medicare participation and billing privileges and it knew why the contractor made that determination. If Petitioner had relevant evidence that would show that Dr. Iguh certified the beneficiaries whose care was at issue for home health services consistent with regulatory requirements it should have offered that evidence at reconsideration. It offers not a single reason for its failure to do so.

Petitioner argues that I should consider these exhibits as "rebuttal" to CMS's motion for summary judgment. It contends essentially that the exhibits establish a fact dispute and that whether there is a fact dispute is a "new issue" that justifies offering evidence that Petitioner failed to present below. This is unpersuasive. There is nothing new about CMS's assertion that Petitioner claimed reimbursement for beneficiaries without obtaining proper certification. Petitioner has known since the inception of this case that this is the central issue of fact.

Furthermore, summary judgment would be appropriate in this case even if I admitted all of Petitioner's exhibits. CMS premises its case on Petitioner's failure to obtain proper certifications for at least ten beneficiaries before claiming reimbursement for its services to those beneficiaries. The evidence now offered by Petitioner relates to only some and not all of those beneficiaries. As I state above, even a single instance of failure to obtain a proper certification justifies revocation of Medicare participation and billing privileges. Consequently, the facts are undisputed as to noncompliance even if there are disputes as to some of the beneficiaries whose care is at issue.

Petitioner acknowledges that it may not have kept records of beneficiaries' care properly and that it may not, in fact, be entitled to reimbursement for the services that it claimed for the beneficiaries whose care is at issue here. However, according to Petitioner, these acknowledged shortcomings "hardly rises to the severity level alleged by CMS, which hints to the perpetration of fraud. . . ." Petitioner's Brief at 10.

Whether or not Petitioner committed fraud is not at issue in this case. CMS premises its determination on Petitioner's failure to obtain proper certifications for home health care services. That failure certainly could be fraudulent but it is unnecessary for me to conclude that it is fraud in order to conclude that failure to

comply with certification requirements is present. In at least several instances Petitioner claimed Medicare reimbursement for services that were provided without obtaining the certifications required by 42 C.F.R. § 424.22(a). That is all that is needed to support the determination to revoke.

/s/
Steven T. Kessel
Administrative Law Judge